

PROJECT HOMELESS CONNECT TRIAGE & SERVICE ROUTING FORM

Consent Form #

Client \_\_\_\_\_

First M.I. Last

SS# \_\_\_\_\_ DOB \_\_\_\_\_

<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____ <b>Has ID:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Age:</b> <input type="checkbox"/> 17 & Under <input type="checkbox"/> 18 - 25 <input type="checkbox"/> 26 – 54 <input type="checkbox"/> 55 – 64 <input type="checkbox"/> 65 & Up	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Partner <input type="checkbox"/> Married <input type="checkbox"/> DP <input type="checkbox"/> Other _____ <input type="checkbox"/> Together	<b>Dependents:</b> <input type="checkbox"/> Minor Children Number _____ Custody <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pregnant <input type="checkbox"/> Due Date _____ <input type="checkbox"/> Pre-Natal Care
--	--	---	---

Have you been to a previous Project Homeless Connect? <input type="checkbox"/> YES	<input type="checkbox"/> Oct. 04 <input type="checkbox"/> Feb 05 <input type="checkbox"/> Jun 05
Were you referred by an agency? _____	<input type="checkbox"/> Dec 04 <input type="checkbox"/> Apr. 05

**WHAT DO YOU WANT FROM TODAY?** ☐Housing ☐Medical ☐Mental Health/Substance Abuse ☐Veterans' Benefits  
☐ Other \_\_\_\_\_ ☐Shelter ☐CAAP/Food Stamps ☐Food ☐SSI/SSDI Advocacy  
☐ Employment Services ☐ Vision Care ☐ HIV Test

**WHAT IS YOUR CURRENT SOURCE OF INCOME, if any?** \_\_\_\_\_

☐ **NO BENEFITS**/UNKNOWN ☐ **CAAP:** ☐ GA ☐ PAES ☐ SSIP ☐ CALM ☐ **FOOD STAMPS** ACTIVE

☐ **SSI/SSDI** ACTIVE ☐ Awaiting Outcome of SSI Application

☐ **VETERAN /MILITARY SERVICE** ☐ Receiving Veterans Benefits? ☐ Would like to discuss Veterans benefits?

**MEDICAL / HEALTH INFORMATION**

☐ **MEDICAL ISSUE** and wants to see a DOCTOR TODAY ☐ Currently receiving treatment at: \_\_\_\_\_  
☐ DENTAL ☐ VISION CARE ☐ Taking MEDS  
☐ OTHER \_\_\_\_\_

☐ Wants an **APPOINTMENT** to see a DOCTOR

☐ Condition or illness affecting your **MOBILITY**? \_\_\_\_\_  
☐ WHEELCHAIR ☐ WALKER ☐ CANE

**BEHAVIORAL HEALTH**

☐ **Mental illness** ☐ **Substance Use** issue affecting ABILITY to FUNCTION? \_\_\_\_\_  
☐ Currently receiving treatment at \_\_\_\_\_ ☐ Taking MEDS

☐ Interested in **TREATMENT** ☐ MENTAL HEALTH TREATMENT ☐ SUBSTANCE ABUSE TREATMENT

☐ Interested in **METHADONE TREATMENT** ☐ Other \_\_\_\_\_

**CURRENT HOUSING SITUATION:**

☐ **USING SHELTERS:** Current placement \_\_\_\_\_

☐ **Currently Sleeping Indoors, other than shelters.** \_\_\_\_\_ ☐ Paying Rent

☐ **Not staying INDOORS:** Where do you sleep? \_\_\_\_\_

**INFORMATION Related To HOUSING:**

☐ **Has PETS:** \_\_\_\_\_ ☐ CERTIFIED COMPANION ANIMAL

☐ **If PARTNERED (above), will consider single Housing:** ☐ Single Transitional/Temporary ☐ Single Permanent

☐ **LEGAL NEEDS / ISSUES:** Would like to talk to a legal counselor regarding: \_\_\_\_\_

<input type="checkbox"/> <b>MEDICAL</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral	<input type="checkbox"/> <b>EMPLOYMENT SERVICES</b> <input type="checkbox"/> _____
<input type="checkbox"/> <b>OTHER HEALTH</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral (Mental Health &/or Substance Use Treatment)	<input type="checkbox"/> <b>LEGAL</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral
<input type="checkbox"/> <b>VISION CARE</b> <input type="checkbox"/> ____ <input type="checkbox"/> <b>HIV TEST</b> <input type="checkbox"/> ____	<input type="checkbox"/> <b>SHELTER Info/Resv</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral
<input type="checkbox"/> <b>CAAP/Food Stamps</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral	<input type="checkbox"/> <b>HOUSING Counsel</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral
<input type="checkbox"/> <b>SSI/SSDI Advocacy</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral	<input type="checkbox"/> <b>FOOD</b> _____
<input type="checkbox"/> <b>Veterans Benefits</b> <input type="checkbox"/> _____ <input type="checkbox"/> Appt./Referral	<input type="checkbox"/> <b>Other</b> _____